Hospital Letterhead

Hospital ABN 5.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

We have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)* and has determined that further hospitalization is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*. The *(name of the QIO)* has concurred with our decision that beginning *(specify date of first noncovered day)* further *(specify services to be furnished or condition to be treated) (specify is/are medically unnecessary)* or *(could be safely furnished in another setting)*. You will also receive a notice from *(name of QIO)* confirming the review decision.

We have advised your attending physician of the denial of further inpatient hospital care. You should discuss other arrangements with your attending physician for any further health care you may require.

If you decide to stay in the hospital, you will be responsible for payment for all services provided to you by this hospital, except for those services for which you are eligible to receive payment under Part B, beginning *(specify date)*.1/

- **If you disagree with this decision:**

  You may request **by telephone or in writing** an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

- **If you do not request an expedited reconsideration:**

  You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by *(name of QIO)*.

- **QIO Reconsideration Results:**

  The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.

  IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

  IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning *(specify date)*.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from _____*Name of Hospital*_____ at _____*Time*_____ on _____*Date*_____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

_____
1/ For PPS hospitals and short term/acute care hospitals in waivered States, insert: the date of the third day following the date of receipt of the hospital notice. For specialty hospital and PPS-exempt units, insert: the date specified by the QIO. The beneficiary's liability begins on the day following the date of receipt of the notice.